The Concept of Health in Nursing Practice

Abstract

Health is a concept at the very heart of nurse education and nursing practice. Yet, it remains a highly dynamic notion that has evolved and changed over time and can be examined from many differing, contrasting and complementary perspectives. This article explores the differing perspectives of health and argues that nurses essentially need to care in a person-centred way in order to explore what the patient or service user's own concept of health is, and to set goals that mirror that personal concept and individual aspirations.

Keywords: To be drawn from the Nursing Standard taxonomy by the Ed team

The World Health Organization's perspective on health

Health is acknowledged to be an abstract and contested concept that is highly subjective and difficult to define (Dixey *et al.*, 2013; Green *et al.*, 2019). A still commonly used definition of health is the one from the World Health Organization (WHO). This suggests that health is 'a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (WHO, 1948 cited in WHO, 2006). This definition is holistic, broad and positive in nature. It moves away from the notion that being healthy is simply about not being ill and, crucially, it takes into account social and mental health which are important dimensions of health, although notably also difficult to define (Green *et al.*, 2019). However, this definition has been criticised for being utopian, unattainable and for not considering other dimensions of health i.e. sexual and emotional health (Huber, 2011; Scriven, 2017). Yet the WHO's conceptualisation of health has not remained static. In 1977 WHO acknowledged that health was 'the ability to conduct a socially and economically productive life' which was a key goal of the then Health for All by the Year 2000 global strategy (WHO, 1977).

In the Ottawa Charter for Health Promotion (WHO, 1986 p. 1) there was a further refinement and it was acknowledged that 'health is created in the context of everyday life and environment, where people live, love, work, and play'. The Ottawa Charter for Health Promotion is an international agreement which was signed at the First International Conference on Health Promotion, organised by the WHO and is considered by many in the field to be the cornerstone of health promotion (Green *et al*., 2019). Svalastog e*t al.* (2017) point out that this development introduced an active and interactive understanding of health.

More recently, there have been discussions about adding the spiritual dimension of health to WHO's definition but, although the dimension of health is increasingly recognised as important it has not yet been revised (Nahr *et al*., 2011; Chirico, 2016). Despite the criticisms levelled at the WHO's definition of health it has stood the test of time in many respects largely because, as discussed, subsequent developments in the WHO agenda have broadened understandings about health.

In simple terms, health can be viewed either positively or negatively. Green *et al.* (2019) refer to this as dichotomous differences in approaches to defining health. Positive approaches to defining health consider health as well-being or as an asset, whilst negative approaches are more concerned with the absence of illness or disease. When health is viewed positively, definitions tend to be broader and to take into account concepts such as well-being and happiness. The WHO definition outlined earlier is an example of a more positive definition and marks a shift in understanding away from a more narrow, medical and largely negative view of health. Other types of definitions draw on the idea that health is about being able to cope and adapt to different circumstances and achieve personal potential and may be more aligned with humanistic perspectives. Drawing on humanist ideas therefore, health might also be considered as self-actualization and many modern concepts of health acknowledge that self-realization and self-fulfilment are important for subjective health (Svalastog et al.,

2017).

The importance of lay concepts of health

The social model of health privileges lay understandings of health in contrast to the medical model which is dominated by expert, scientific views (Green *et al.*, 2019). Lay understandings or concepts refer to "non-expert" perspectives. Many things influence our understandings of what health *is*, our gender, our age, our health status, our culture, our ethnicity, our social class, how we live, what we do (occupation) and where we live (geographical location and country). A substantial amount of research has been undertaken that explores lay beliefs and understandings about health in at different times in different contexts. Whilst understandings do vary according to a number of different factors there are some common themes across the findings. Much of the research points to the importance that people in different contexts place on being able to *function* or to carry out the activities in daily life that enable a person to live, work and enjoy their leisure time (Stainton-Rogers, 1991; Blaxter, 2010). Health is often equated with being *fit* (Wright *et al.*, 2006) or with *not being ill* (Blaxter, 2010), ideas which resonate with the medical model of health. It is also viewed as a *resource* for living (Bopp *et al*, 2012). More complex, sophisticated understandings are also apparent however, such as health being about a kind of *balance or equilibrium* (Omonzejele, 2008; Robertson, 2006) and about having a sense of *well-being or happiness* (Bishop and Yardley, 2010; Cloninger and Zohar, 2011). Clearly, as Green *et al.* (2019:11) argue, 'lay interpretations [of health] are complex and multidimensional'. Table 1 illustrates some of this diversity.

Table 1: Examples of lay health concepts		
Population	**Findings**	**Source**

U.S. college students	Four components of health: 1. Social-Emotional Health 2. Positive Health Practices 3. Absence of Stress/Anxiety 4. Adequate Rest	Downey and Chang (2013)
Korean mothers living in the U.S.	Conceptualised health in relation to their role as a mother, being able to care for their children first and foremost	Cha (2013)
Māori concepts of health (New Zealand)	Four dimensions of health: 1. *Hinengaro* (mental health - recognising the inseparability of mind and body; expressing thoughts and feelings), 2. *Wairua* (spiritual health - unseen and unspoken energies; faith and spiritual awareness), 3. *Whānau* (health of the extended family – wider social systems; belonging, sharing and caring) 4. *Tinana* (physical health – good physical health)	Rolleston *et al.*, (2016: 61).

Native Americans, Alaska Native and Native Hawaiians	Concepts of health were closely tied to the concepts of community, spirit, and the land.	Bradley *et al*. (2017)
Women in Nepal	Concepts of health were related to the absence of disease, peace in the family and being able to work.	Yang *et al.* (2018).

Bishop and Yardley (2010: 272) analysed qualitative studies of lay definitions of health and identified three major themes in the findings across the studies. These were 1) health as the absence of illness - 'health is something that one *is*', 2) health as the ability to perform daily activities - 'health can be something that one *has'*, and 3) health as experiences of vitality and balance - 'health can be something that one *does'*. In short, health is about 'having, being and doing' (Bishop and Yardley, 2010: 273). More recently Svalastog et al. (2017: 434) contended that the lay perspective on health is characterised by three qualities: wholeness, pragmatism, and individualism. See Table 2 for further details.

Table 2: The lay perspective on health (adapted from Svalastog et al, 2017, p. 434)

Quality	**Explanation**
Wholeness	This is related to health as 'holistic'. Health is viewed as intrinsic to all other aspects of life including work, family and community. Health is also viewed as a resource for living and as the ability to function. In addition, to be able to live according to one's values is also important.
Pragmatism	This reflects health as a relative experience. Health is

	viewed and experienced according to what people might reasonably expect in the light of their personal circumstances (age, health condition/s and social situation). Other positive values in life can compensate for disability or disease.
Individualism	Health is conceptualised as a very personal phenomenon. This depends on who you are as a person however, feeling close to others and part of a community or society is an important factor.

Lay understandings of health and illness often encompass medical understandings and this is particularly the case in more wealthy, developed contexts where the medical model of health dominates ('western' countries) (Shaw, 2002). For instance, Green *et al.,* (2019) note how germ theory has been subsumed into most 'western' lay concepts of illness. This is inevitable because we constantly interact with the world around us and our opinions and beliefs are influenced by many different things including our interactions with healthcare professionals and the information that is available to us. Lay perspectives are informed by many different things aside from medical and scientific knowledge. History (personal and collective), other people, the internet, mass media, and our own personal experience all have a bearing. In addition, social media has increasing influence on lay perspectives of health and illness (Baker and Rojeck, 2019).

'Understandings of health are constructed by interactions between people in the real world' (Dixey, 2013: 40). Expert models of knowledge (those that rely on scientific interpretations of the world) tend to ignore people's everyday experiences and reality (Cross *et al.,* 2017). In addition, 'lay perspectives are often regarded as irrational and trivial in contrast to the

rational […] view of the so-called experts' (Green *et al.*, 2019: 91). The problem is that, if people's experiences and knowledge are not taken into account, there is a risk that the experts can get it wrong i.e. that there will not be enough understanding of an issue for it to be dealt with in the most successful way. Lay understandings about health and illness causation can be very different to expert, medical and scientific understandings. For example, we know that strokes are caused by a number of risk factors such as high blood pressure, being overweight, and physical inactivity however, Moorley *et al.*'s (2016) study on African-Caribbean women's lay beliefs about the causes of stroke revealed alternative explanations related to witchcraft and curses.

Historically, as noted by Green *et al.,* (2019) earlier, lay understandings of health and illness have been devalued and dismissed with more importance being given to medical expertise however, this is changing. After all, we all each have the best knowledge of our own lived experiences and the circumstances of our personal lives. In the study mentioned previously the authors concluded that 'lay beliefs such as witchcraft can co-exist amicably alongside modern medicine, as long as they do not hinder access to medication, treatment or risk factor management of stroke' (Moorley *et al.,* 2016: 403). It is important to appreciate different perspectives in order to tackle certain diseases in some communities. It is also important to acknowledge lay perspectives because they inform peoples' capacity to self-care and manage their own (ill) health which can reduce the strain on healthcare services.

Health as wellbeing and happiness

The concept of wellbeing, like health, is difficult to define however it is receiving increasing attention in the wider literature. Wellbeing is closely linked to health. There is a general appreciation in the literature that wellbeing has three major aspects to it: physical, social and

psychological (Grant *et al.,* 2007). Physical wellbeing is concerned with healthy functioning, fitness and performance, social is concerned with interpersonal relationships and community involvement), and psychological is concerned with the ability to cope or adapt. According to Johnson et al. (2016) well-being also includes having one's basic psychological needs met, experiencing positive emotions, engaging with others, having meaningful relationships, and achieving things. Wellbeing is often closely associated with mental health (Gu *et al.,* 2015) and social connection is proven to be inextricably linked to health experience (Seppala et al., 2013).

Wellbeing and happiness are connected. They are also fundamentally related to what it means to be or feel healthy. As stated, subjective experiences of health, including ideas about well-being and happiness, are receiving increasing attention, particularly in terms of evaluating health outcomes. Happiness, however, is perhaps easier to define than wellbeing and can be simply understood as a human state that exists in opposition to sadness. We tend to put a high value on being happy and many people actually equate feeling happy with feeling or being healthy. There is an expanding field of research exploring the relationship between health and happiness. For example Angner *et al.*'s (2009) work examined health and happiness among older people and found that subjective measures of health (notions of well-being) were much better predictors of happiness that objective measures (illness and infirmity). In a Thai study on health and happiness mental health and social support were strongly correlated with happiness (Yiengprugsawan *et al.,* 2012). Similar results can be found across the literature and The World Economic Forum (2015) has recognised the importance of finding better measures of lived experience than simply looking at how much money someone has. Quality of life is another important and related concept. Most people would agree that it is quality of life that is important, as compared to quantity of life (or

number of years lived).

Salutogenic concepts of health

Another important concept of note in ideas about health is *salutogenesis.* In the medical model of health the focus is on pathogenesis or what causes/creates illness and disease. This is a concept that nurses will be very familiar with. In contrast, salutogenesis focuses on what causes, creates or supports health (Svalastog et al., 2017). Antonovsky (1996) developed this idea as a challenge to the pathogenic nature of the medical model and argued that in order to optimise the human health experience the focus should be on wellness, not illness. He advocated for an understanding of health as a continuum arguing that we are never fully achieve a 100% healthy state but rather because we are essentially biological beings, we are continually moving somewhere between states of ill-health and health (called the 'health-ease-dis-ease continuum'). Antonovsky (1996) argued that the focus should be on 'symptoms of wellness' rather than the causes of disease and that, given that we are all organisms, we should accept that we will, at times, have things wrong with us (i.e. get sick). In addition, Antonosky developed ideas around what he called a 'sense of coherence' which is comprised of three main elements – comprehensibility, meaningfulness and manageability. In short, comprehensibility is about how we understand our worlds and make sense of them, meaningfulness is about how we feel about these and manageability is about the extent to which we can cope with what life throws at us (Sidell, 2010). More positive, agentic, asset-based ideas about health can be described as being 'salutogenic' in nature. For the most part however, in Western cultures at least, when we talk about health we are actually talking about negative health experience or 'ill--health' rather than more positive notions of health.

Healthworlds

Finally Germond and Cochrane (2010) talk about 'healthworlds', a concept that has direct relevance to this discussion. Healthworlds relate to 'people's conceptions of health, to their health-seeking behaviour, and to their conditions of health. Individual's healthworlds are shaped by, and simultaneously affect, their social shared healthworld constituted by the collective search for health and well-being' (Germond and Cochrane, 2010 p. 309). Healthworlds are not static and consistent however, they change as people (and communities) change. With reference to the acceptability of pharmaceutical intervention in the United States, Adams *et al.* (2019) noted how minority ethnic groups, particularly those who are less acculturated to western culture (and therefore western medicine), were more sceptical about using prescription drugs. Their healthworlds were not as narrowly focused on western medicine as a treatment option as the majority of the population's was. Fried *et al.*'s (2015) research in South Africa into the acceptability of tuberculosis treatment and antiretroviral therapy concluded that the patients' healthworlds needed to be acknowledged and incorporated into patient-provider interactions and that the importance of this was underestimated which had significant implications for policy and practice.

Conclusion

In summary health is a complex phenomenon and this has implications for how we work with people in all kinds of settings. Only the person themselves can determine whether or not they feel healthy and what they need to order to achieve their optimum health state. This means that nurses need to listen to patients and service users, and establish what their personal ideas of health are. It means getting to know your patient and ascertaining what they want to achieve. A young, able-bodied athlete is likely to have very different ideas about what it means to be healthy as compared with a middle-aged mum with teenage children or a retired widower. Respectively these might be being fit, managing caring responsibilities and coping with being alone. Clearly effective communication and patient-centred care is at the heart of

this (Barratt, 2018). Equally an approach that promotes shared decision would be important as understanding what people want and need, then supporting them in achieving that, are important facets of individualised care (Madsen and Fraser, 2015). For more information on optimising communication and joint decision-making in the nurse-patient relationship please see Barrett (2018) and Madsen and Fraser (2015). Finally, nurses will appreciate the argument that 'pain is what the patient says it is' (Miller *et al.,* 2017). Given the subjective nature of health and the highly individual nature of health experience perhaps we should be acknowledging that *health is what the person says it is* and recognising that this should determine how we respond to, and work with, the people who we care for.

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